I. BENEFICIARY RIGHTS & ISSUE RESOLUTION

The County of San Diego's Mental Health Beneficiary Problem Resolution Process is a part of the County Mental Health Plan (MHP). In July of 2005 a new process was developed in response to new federal requirements. A copy of the revised Beneficiary Problem Resolution Process has been included as part of the Quick Reference Section of this Handbook. Providers/facilities should refer to this section to review their responsibility in helping to resolve client dissatisfaction with services.

In accordance with Title 9, the MHP Quality Improvement Unit distributes the Guide to Medi-Cal Mental Health Services which contains both a description of the services available through the MHP and the avenues to obtain resolution of dissatisfaction with MHP services. These avenues include talking with program staff, obtaining a second opinion, and filing a grievance/appeal. The Guide also includes instructions on obtaining a State fair hearing.

> *Note: New clients must be offered a copy of the Guide when they first obtain services from the provider and upon request, thereafter. (Guides are available in threshold language of English, Spanish, Arabic, and Vietnamese). Additional copies may be obtained from the MHP Quality Management Unit at 619-563-2776. The chart should document review of client rights at intake and at least annually thereafter.*

Provider Selection

In accordance with 42 CFR 438.6 and Title 9, providers are reminded that clients have the right to obtain a list of MHP providers, including information on their location, hours of service, type of services offered, and areas of cultural and linguistic competence. A Provider List which is available through the QI Unit shall be offered at intake, and noted in the beneficiary's medical record. Additionally, this information is posted on the County's website, under Mental Health Services, where it can be periodically updated. (Similar information on fee-for-service providers is available from UBH.) When feasible, and at the request of the beneficiary, beneficiaries will be provided with the initial choice about the person who provides specialty mental health services, including the right to use culturally specific providers. Requests for a change of provider, either within a program or to a new program, should be documented on the Suggestion and Provider Transfer Request Log.

Advance Health Care Directive Information

Federal Medicaid regulations (42 CFR 422.128) require the MHP to ensure that all adults over age 18 and emancipated minor Medi-Cal beneficiaries are provided with information about the right to have an Advance Health Care Directive. In order to be in full compliance with this regulation, it is necessary that all eligible clients be informed of the right to have an Advance

Health Care Directive at their first face-to-face contact for services, or when they become eligible (upon their 18 birthday or emancipation). Advance Health Care Directive is defined in the Code of Federal Regulations 42, Chapter IV, Part 489.100 as "a written instruction such as a living will or durable power of attorney for healthcare, recognized under State law (whether statutory or recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." Generally, Advance Health Care Directives deal with how physical health care should be provided when an individual is incapacitated by a serious health care condition, such as a stroke or coma, and unable to make medical treatment decisions for themselves.

In order to be in compliance with the Federal regulations (42 CFR, Chapter IV, Section 422-128), providers shall do the following for new clients:

1. Provide written information on the client right to make decisions concerning medical treatment, including the right to accept or refuse medical care and the right to formulate Advance Directives, at the first face-to-face contact with a new client, and thereafter, upon request.
2. Document in the client's medical record that this information has been given and whether or not the client has an existing Advance Directive.
3. If the client who has an Advance Directive wishes to bring in a copy, the provider shall add it to the client's current medical record.
4. If a client is incapacitated at the time of initial enrollment and unable to receive information, the provider will have a follow-up procedure in place to ensure that the information on the right to an Advance Directive is given to the client at the appropriate time. In the interim, the provider may choose to give a copy of the information to the client's family or surrogate.
5. Not condition the provision of care or otherwise discriminate against an individual based on whether or not he or she has an Advance Directive.
6. Should the situation ever arise, provide information about the State contact point to clients who wish to complain about non-compliance with an Advance Directive.

The MHP is providing an informational brochure on Advance Directives, available in the threshold languages, which can be given out to new clients or members of the community who request it. Copies may be obtained through the MHP QI Unit by calling (619) 563-2776, or providers may duplicate their own copies. The MHP will also be responsible for notifying providers of any changes in State law regarding Advance Directives within 90 days of the law change.

Providers are expected to formulate their own policies and procedures on Advance Health Care Directives and educate staff. Because of the legal nature of Advance Directives, providers may wish to consult with their own legal counsel regarding federal regulations.

Providers are required to provide all clients who fit the criteria with this information and document in the medical record that clients have received the required information. Copies of the brochure in threshold languages and sample forms may be obtained from the QI Department. Additionally, the Advance Directive Advisement form (MHS-611) found in the Documentation and Uniform Clinical Record Manual shall be completed.

Language Assistance

Clients should be routinely asked, at the time of accessing services, about their need for language assistance, including the option to receive services in their preferred language, if possible, or to receive interpreter services. They shall be routinely informed about the availability of free language assistance at the time of accessing services. Limited English Proficiency posters shall be posted in threshold languages at Program site, and can be obtained from the QI Unit. Clients may not be expected to use family or friends for interpreter services. However, if the client so chooses, this choice is to be documented in the client record. According to Title 9 and the County Policy, providers must document the offer of assistance and the linkage to interpreter service for clients requesting or needing translation services in threshold or other languages. Interpreters can be qualified staff members at the provider site. Consistent with the County Mental Health Cultural Competency Plan, providers are required to develop staff's language competence for threshold languages, currently English, Spanish, Arabic, and Vietnamese. If no qualified staff is available, the interpreter should be selected from among those approved by and who contract with the MHP to provide translation services. Accordingly, provider staff, with the approval of the program manager or designee, can contact Interpreters Unlimited (for language interpreting) at 858-451-7490 or Deaf Community Services (for deaf and hearing-impaired clients) at 800-284-1043 to arrange the needed services. As soon as the services have been rendered, the provider will fill out a Service Authorization Form (copy included in the Quick Reference section of this Handbook) including:

- The requestor's name
- Organization and program name
- Program Manager's address, phone and fax numbers
- Name and social security number of the client
- The language requested
- The type of clinical need

The completed form will be faxed to Interpreters Unlimited or Deaf Community Services, as appropriate. Upon rendering of the services, the interpreter is to sign off on the form.
The interpreting services will then submit an invoice to the MHP.

Providers must also be able to provide persons with visual or hearing impairment, or other disability, with information on Mental Health Plan Services, making every effort to

accommodate individual's preferred method of communication, in accordance again with Title 9 and County Policy.

Client Right to A Second Opinion

If the MHP or its designee determines that a client does not meet Title 9 Medical Necessity Criteria for inpatient or outpatient mental health services, a client may request a second opinion. A second opinion provides the client with an opportunity to receive additional input for treatment recommendations or treatment planning. The client, or someone on behalf of the client, may request a second opinion. As the MHP agent, UBH is responsible for informing the treating provider of the second opinion request and for arranging the second opinion with an MHP contracted individual provider.

State Fair Hearing

The second opinion provider is required to obtain a release of information from the client in order to review the client's medical record and discuss the client's treatment. After the second opinion evaluation is completed, the second opinion provider forwards a report to the MHP Program Monitor for review. If the second opinion request occurs due to a denial of authorization for payment, the MHP Clinical Director may uphold the original denial decision or may reverse it and authorize payment.

Notice of Action-Assessment (NOA-A)

Organizational provider and county-operated programs that assess/screen a Medi-Cal beneficiary as not meeting the medical necessity criteria for outpatient Specialty Mental Health Services must give the client a Notice of Action-Assessment (NOA-A). Assessment / screening may be face to face or by phone utilizing the Assessment form (MHS-650 or MHS-663) or Initial Screening Form (MHS-607). NOA-A's must be logged in the NOA Log, which shall be maintained at the facility, and a copy faxed to their Program Monitor for months in which an NOA occurs. The NOA-A summary shall be included in the Monthly Status Report when an NOA-A is issued. Program Monitor shall forward a copy of NOA-A and Log to the QI Unit for tracking and trending purposes. The back of the NOA-A form explains to the Medi-Cal beneficiary his or her right to a second opinion and his or her right to request a State Fair Hearing. However, per DMH Letter 05-03, beneficiaries are required to exhaust the MHP's appeal process prior to filing for a State Fair Hearing. The beneficiary must first contact the Consumer Center for Health Education and Advocacy (CCHEA) at (877) 734-3258. A client may call the Access and Crisis Line to request a second opinion, and will be connected to a provider for a face-to-face assessment.

When the medical necessity criteria for Specialty Mental Health Services are not met, organizational and county-operated providers should refer the client to alternative appropriate community services. The client may also be referred to the Access and Crisis Line for other referrals to community-based services.

Notice of Action - B (NOA-B)

In response to a provider's request for continued treatment authorization, if the MHP or its designee should determine that a Medi-Cal client's treatment be denied, modified or reduced, the provider and the client will receive an NOA-B form. The NOA-Back form describes the Medi-Cal client's right to file a grievance/appeal, and the right to a State Fair Hearing. Please review the NOA-B with the client and request that he/she sign the form, and return the signed NOA-B to the point of authorization.

If the Medi-Cal client chooses to exercise the right to obtain a second opinion, or the right to file an appeal, or request a State Fair Hearing, the appropriate state or county offices to contact are given on the reverse side of the NOA forms. (This form is known as the NOA-Back.) A copy of the NOA-A and B forms and the NOA-Back are included in the Quick Reference section of this manual. Please copy them for your use. Note that NOA forms were updated in August 2005.

Additional Types of Notices of Action

In response to 42 CFR, Notices of Action must be sent out for two additional reasons:

1. A Notice of Action form will be sent to a client from an advocacy organization (CCHEA or USD Patient Advocacy) or the MHP, as appropriate, if a grievance, appeal, or expedited appeal is not completed in accordance with federal timelines. (NOA-E)

2. A Notice of Action form will be sent to a client from UBH or Telecare if a Treatment Authorization Request (TAR) has been denied as a result of insufficient information submitted by the provider. (NOA-C)

It is expected that issuing these types of NOAs will be infrequent, but may result in clients approaching providers with a few questions. The State has provided the counties with specific forms for these new NOAs.

Client Grievances and Appeals

The Mental Health Problem Resolution process covers Medi-Cal beneficiaries, SED-certified children through the Healthy Families program, and persons without Medi-Cal funds receiving county-funded mental health services. It is designed to meet the regulations in CCR Title 9, Division 1, Chapter 11, Subchapter 5, Section 1850.205 and 42 CRF Subpart F, Part 438.400. By law, Welfare and Institution (WI) Code WI 19950, the State Fair Hearing process is only available to a Medi-Cal beneficiary.

Problem Resolution

Consumer Center for Health Education and Advocacy (CCHEA) – (877) 734-3258

USD Patient Advocacy – (800) 479-2233

Rev. January 2006

BENEFICIARY RIGHTS & ISSUE RESOLUTION

Consumers in the MHP shall be informed in a clear and concise way of the process for reporting and resolving grievances and appeals. Consistent with the principle of a consumer driven system of care, the consumer grievance and appeal process has been developed through a collaborative process with consumers, family members, the University of San Diego (USD) Patient Advocacy Program, the Center for Consumer Health Education & Advocacy (CCHEA) and County of San Diego Mental Health Services staff. The grievance and appeals process includes information on how to contact the Center for Health Education and Advocacy (CCHEA) and USD Patient Advocacy Program. These agencies are under contract with the MHP and are responsible for investigating and tracking grievances and appeals.

Grievance/appeal materials prepared as part of that process include display posters, descriptive brochures, fill-in forms and envelopes. In accordance with the California Code of Regulations, Title 9, Chapter 22, Subchapter 5, Section 1850.205, grievance and appeal materials must be available at all provider sites, visible, and available for clients and families to pick up without having to make a verbal or written request. Materials shall be available in the threshold languages (English, Spanish, Arabic, and Vietnamese) and shall be offered to the client at the point of intake to a program and, as appropriate, during the provision of services (Supplies of these items may be obtained by contacting County MHS Quality Improvement Unit at 619-563-2776). Providers are required to review the grievance materials annually with clients and this activity should be noted in the chart. It is suggested that the anniversary of the Admission Date to the program be used as a review point.

Consumers shall not be subject to any discrimination, penalty, sanction or restriction for filing a grievance or appeal. The consumer shall not be discouraged, hindered, or otherwise interfered with in seeking or attempting to register a grievance or appeal. Additionally, the beneficiary is not required to present a concern in writing.

Some client issues can be easily handled at the program level, as suggestions to program operation. Consumers have a right to request a transfer from one provider to another, within or outside of a program. Providers are required to maintain a log of requests for transfer to a new provider, and "suggestions" should be entered on the same log: the Suggestion and Provider Transfer Request Log. The log must include the following elements:

- Date the request was received,
- Whether it was a suggestion or provider transfer request,
- The suggestion or transfer code,
- Whether the transfer request was to a provider within or outside of the program
- Description of the suggestion or transfer request
- Date of resolution
- Resolution/action taken

The log shall be submitted with the provider's Monthly Status Report. In addition, QI staff may request to view the log during a site visit or medical record review. Grievances and appeals need not be logged by the provider, but the client should be assisted in contacting CCHEA or USD Patient Advocacy as appropriate.

The MHP, operating from a shared concern with providers about improving the quality of care and service, will view feedback from the grievance and appeal process and from the Suggestions and Provider Transfer Request logs as a reflection of potential problems with service effectiveness and/or efficiency and an opportunity for positive change. Information on problems may be incorporated into the ongoing contract monitoring and/or credentialing process.

Grievance Process

Timeline: 60 days from receipt of grievance to resolution, with a possible 14-day extension for good cause.

A "grievance" has been defined as an expression of dissatisfaction about any matter other than an action. USD Patient Advocacy facilitates the grievance process for clients in inpatient and other 24-hour residential facilities. CCHEA facilitates the grievance process for outpatient and all other mental health services. These advocacy services will contact providers within three (3) days of receiving written permission from the client to represent him/her. Securing this permission can be difficult and time consuming. In order to be in compliance with the mandated federal timeline, providers shall work closely with the Advocacy organization to find a mutually agreeable solution to resolve the grievance quickly.

If a grievance or appeal is about a clinical issue, CCHEA and USD Patient Advocacy Program, as required by 42 CFR, will be utilizing a clinician with appropriate clinical expertise in treating the client's condition to review and make a decision about the case.

Appeal Process

Timeline: 45 days from receipt of appeal to resolution, with a possible 14-day extension for good cause.

Appeals are reviews of actions by the MHP regarding provision of services through an authorization process, including:

- Reduction or limitation of services
- Reduction, suspension or termination of a previously authorized service
- Denial of, in whole or part, payment for services
- Failure to provide services in a timely manner

See the Beneficiary Problem Resolution Process in *Section O, Attachment 19* for details. The Advocacy organization will contact the provider within three (3) working days of receiving the written permission to represent the client. Again, the provider's cooperation with the Advocacy organization to find a mutually agreeable solution is necessary to meet the strict mandated timelines in resolving the problem. The advocacy organization shall investigate the appealed matter and make a recommendation to the MHP. The MHP (Local Mental Health Director or designee) will review the recommendations of the advocacy organization and make a decision on the appealed matter.

Note: A decision by a therapist to limit, reduce, or terminate a client's service is considered a clinical decision and cannot be the subject of an appeal, however, it can be grieved.

Expedited Appeal Process

Timeline: Three (3) working days, with a possible 14-day extension for good cause.

When the standard appeal process could jeopardize a client's life, health or functioning, an expedited appeal may be filed for by the Advocacy organization, necessitating a very rapid turnaround from grievance to resolution. The advocacy organization will notify the provider as soon as possible, but in less than two (2) working days. The Mental Health Director will make a decision on the appeal on the third working day.

State Fair Hearing

Medi-Cal beneficiaries filing an appeal may request a State Fair Hearing, after using the County Beneficiary Problem Resolution Process whether or not they have received a Notice of Action within 90 days after the completion of the Beneficiary Problem Resolution Process. State Fair Hearings are further discussed in the Beneficiary Problem Resolution Process in *Section O, Attachment 20*.

Provider Appeal Process

If the provider and advocacy organization cannot successfully resolve the client's grievance or appeal, the advocacy organization will issue a finding, to be sent to the client, provider and Mental Health Director, which may include the need for a Plan of Correction to be submitted by the provider to the Mental Health Director or designee within 10 days. In the rare instances when the provider disagrees with the disposition of the grievance/appeal and/or does not agree to write a Plan of Correction, the provider may write to the Mental Health Director within 10 days, requesting an administrative review. The Mental Health Director or his designee shall have the final decision about needed action. Please see the Beneficiary Problem Resolution Process in *Appendix F* for details of this portion of the process.

Monitoring the Beneficiary Problem Resolution Process

The MHP, operating from a shared concern with providers about improving the quality of care and service, will view feedback from the grievance/appeal process as a reflection of potential problems with service effectiveness and/or efficiency and as an opportunity for positive change. Information on problems may be incorporated into the ongoing contract monitoring and/or credentialing process.

Periodic Notice of Client Rights

In accordance with DMH regulations, written and oral information explaining the grievance and appeal procedures, and the availability of a State Fair Hearing shall be offered to clients upon admission to each program, along with a Guide to Medi-Cal Mental Health Services. The date of this activity shall be reflected on the Behavioral Health Assessment (MHS-650) and/or Behavioral Health Update (MHS-663) form. Information on the beneficiary Problem Resolution Process and fair hearing rights must be provided annually and documented in the medical record. It is strongly recommended that this information be tied to the anniversary date of the client's episode opening.